The Health of New Hampshire's Community Hospital System

A Financial Analysis

St. Joseph's Hospital




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An Important Message to Readers of the Hospital Financial Analysis from the New Hampshire Department of Health and Human Services

February 2001

Introduction

The following Hospital Financial Analysis is a byproduct of the December 13 report, *The Health of New Hampshire's Community Hospital System*, issued by the New Hampshire Department of Health and Human Services. The individual financial narratives are part of a series of analyses addressing the financial condition of the state's health care system.

In the following report, you will find an analysis of the hospital's financial well being from 1993-1998, and **then an additional analysis** that covers the most recent period for which information is currently available, 1999. As audited financial statements for 2000 become available from the hospitals, this information will be updated.

Each hospital financial analysis is broken into five sections. These include:

- Background information on the hospital size, location, payor mix and affiliates;
- A Summary of the Financial Analysis;
- A Cash Flow Analysis;
- An Analysis of Profitability, Liquidity and Capital; and
- An Estimation of Charity Care and Community Benefits

Financial Benchmarks

Financial benchmarks include traditional measures of profitability, liquidity, solvency, and cash flow. Each of these areas of analysis is defined below. Additional information about the ratios or the nature of financial analysis can be obtained by consulting health care financial texts (Gibson 1992; Cleverley 1992).

Profitability:	Purpose	Calculation
Total Margin	Measures the organization's ability to cover expenses with revenues from all sources	Ratio of (Operating Income and Nonoperating Revenues)/Total Revenues
Operating Margin	Measures the organization's ability to cover operating expenses with operating revenues	Ratio of Operating Income/Total Operating Revenue
PPS Payment/Cost	Measures the relationship between Medicare PPS payments and Medicare PPS costs; numbers above 1 indicate that payments exceed costs	Ratio of Medicare Prospective Payment System (PPS) Payments /PPS Costs, derived from Medicare Cost Reports
Non-PPS Payment/Cost	Measures the relationship between payment and costs of all payment sources other than Medicare PPS[1]	Ratio of (Total Operating Revenue minus PPS Payments) / (Total Operating Cost minus PPS Costs)
Markup Ratio	Measures the relationship between hospital-set charges and hospital operating costs; generally only self-pay and indemnity payers pay hospital charges	Ratio of (Gross Patient Service Charges Plus Other Operating Revenue) / Total Operating Expense
Deductible Ratio	Measures the relationship between hospital's contractual discounts negotiated with (private payers) or taken by payers (Medicare and Medicaid) and hospital charges	Ratio of Contractual Adjustments/Gross Patient Service Revenue
Nonoperating Revenue Contribution	Measures the contribution of nonoperating revenues (activities that are peripheral to a hospital's central mission) to total surplus or deficit	Ratio of Nonoperating Revenues (includes unrestricted donations, investment income, realized gains (losses) on investments and peripheral activities)/Excess Revenue over Expense
Realized Gains to Net Income	Measures the contribution of realized gains (a subset of nonoperating revenues) to total surplus or deficit	Ratio of realized gains (losses)/Excess Revenue over Expense

[1] Medicare's Prospective Payment System includes only inpatient-related operating and capital costs and excludes Medicare payments for outpatient costs, which have not been part of PPS through 1998

Liquidity:		
Current Ratio	Measures the extent to which current assets are available to meet current liabilities	Current Assets/Current Liabilities
Days in Accounts Receivables	Measures how quickly revenues are collected from patients/payers	Patient Accounts Receivable/(Net Patient Service Revenue / 365)
Average Pay Period	Measures how quickly employees and outside vendors are paid by the hospital	(Accounts Payable and Accrued Expenses)/ (Average Daily Cash Operating Expenses)[2]
Days Cash on Hand	Measures how many days the hospital could continue to operate if no additional cash were collected	(Cash plus short-term investments plus noncurrent investments classified as Board Designated)/(Average Daily Cash Operating Expenses)
Solvency:		
Equity Financing Ratio	Measures the percentage of the hospital's capital structure that is equity (as opposed to debt, which must be repaid)	Unrestricted Net Assets/Total Assets
Cash Flow to Total Debt	Measures the ability of the hospital to pay off all debt with cash generated by operating and nonoperating activities	(Total Surplus (Deficit) plus Depreciation and Amortization Expense)/Total Liabilities
Average Age of Plant	Measures the relative age of fixed assets	Accumulated Depreciation/ Depreciation Expense

Hospitals As Integrated Systems of Care

Many of New Hampshire's hospitals have developed into systems of care with complex corporate organizational structures. Hospitals may be owned by a holding company or may themselves own other subsidiaries. (The hospital corporate organization charts will be made available with these financial narratives at a future date.) These individual analyses that follow attempt to isolate the hospital entity to the extent possible as the basis of analysis. This distinction is important because subsidiaries that operate within a larger hospital system may operate at higher or lower levels of financial performance than the hospital. For example, a home health agency impacted by Medicare reimbursement changes that result in an operating deficit might be directly supported by the hospital. On the other hand, an ambulatory surgical unit (or another entity within the holding company of which the hospital is a part of) with a healthy financial performance could have a positive impact on the hospital with an operating deficit.

[2] (Operating Expenses Less Depreciation Expense Less Bad Debt Expense)/365

Charity Care and Community Benefits

Each hospital financial analysis includes a section on Charity Care and Community Benefits. This section of the hospital financial narrative is more exploratory than are the other standardized financial benchmarks. For further background information or for specific information on how these measures were calculated, please see the *Analysis of Health Care Charitable Trusts in the State of New Hampshire.*

In 1999, the legislature passed the New Hampshire Community Benefits law (SB 69), which requires that all non-profit hospitals and other health care charitable trusts with $100,000 or more in their total fund balance complete a needs assessment of the communities that they serve. The legislation also calls for the hospitals and others to consult with members of the public within their communities to discuss what the provider has done in the past to meet community needs, what it plans to do in the future, and then submit the plan to the Attorney General's office.

New Hampshire's law is a reporting statute. It does not contain a dollar value or minimum threshold the non-profit trusts must meet. With this new statute, the hospitals and others are working to improve the measurement of charity care (free care) and other community benefits they provide in return for exemption from local, state and federal taxes. Since this law is relatively new, the audited financial statements used for the purpose of this community benefit analysis may not yet fully reflect the dollar value of community benefits beyond charges foregone for charity care or necessary but unprofitable services. New Hampshire's definition of community benefits is very broad; it includes free care but does not include bad debt or shortfalls in reimbursement from the Medicare and Medicaid programs.

Acknowledgements

The Department wishes to thank the following individuals and organizations for making this financial analysis possible. First, this project was made possible through a grant from The Robert Wood Johnson Foundation's *Access Project*, directed by Catherine Dunham, Ed.D. Second, Dr. Nancy Kane and her graduate students at the Harvard School of Public Health prepared the financial analysis and narratives. Finally, the Department extends its appreciation to the Chief Financial Officers and Presidents of each New Hampshire hospital for reviewing the standardized financial spreadsheets and financial analysis to ensure their accuracy.

For More Information

Questions or comment concerning this report may be directed to the Office of Planning and Research at 603-271-5254.

MOODY'S BOND RATING: BAA2
STANDARD & POOR'S BOND RATING: BBB+

ST. JOSEPH'S HOSPITAL, NASHUA, NEW HAMPSHIRE 1993 –1998 FINANCIAL ANALYSIS

St. Joseph's Hospital is a 208 acute-care bed facility primarily serving residents of southern New Hampshire (Hillsborough County) and northern Massachusetts[3]. As of 1997, private insurers represented the largest percentage of payers for inpatient discharges (59%)[4].

Covenant Health Systems, Inc., is the not-for-profit parent company of the hospital. Financial statements represented the hospital alone until 1997, when they were consolidated to include subsidiaries previously accounted for by the equity method. The hospital wholly owns these subsidiaries: the Surgi Center at St. Joseph Hospital, a nonprofit organization providing ambulatory surgical services, and St. Joseph Hospital Corporate Services, Inc. (SJHCS), a for-profit entity that serves as a holding company for other for-profit subsidiaries. Additionally, the hospital assumed operations of Souhegan Nursing Association, Inc., in 1996, but did not assume the existing assets and liabilities; operations for Souhegan were included in the hospital's income statements in 1997 and 1998. The hospital and these entities are referred to as the System.

In 1997, Covenant entered an agreement with Optima Health, Inc., and delegated control of the hospital system's assets and operations to Optima Healthcare Corporation, Inc., a not-for-profit operating company. As a part of Optima, the hospital was affiliated with Catholic Medical Center, Elliot Hospital, and several other health care organizations.

Summary of Financial Analysis 1993-98
The hospital's financial performance over this period was poor, due mostly to the hospital's support of its subsidiaries, specifically St. Joseph Hospital Corporate Services, Inc. Affiliate transactions negatively affected the hospital's equity as a result of their negative effect on the hospital's bottom line and the direct equity transfers required from the hospital. Declining profitability, liquidity and solvency ratios are evidence that the hospital has increased overall financial risk.

Cash Flow Analysis 1993-98
Over the six-year period, the hospital generated most of its cash internally, 65% from depreciation and other noncash expenses, and 18% from operating income. Equity sources of capital would have been greater without the losses of the subsidiaries, namely SJHCS, whose weak performance lead to the hospital's nonoperating losses and subsequent decline in net income. After subsidiaries were consolidated in 1997, these losses were reflected directly in decreased operating income, which decreased cash flow from this source as well.

Investment in property, plant, and equipment (PP&E) required 41% of the total cash flow ($22M), which was roughly commensurate with depreciation expense over the period ($23M). This level of investment seems adequate, as the hospital was able to maintain an average of plant of 8.9 years as of 1998, roughly what it was in 1992.

[3] The 1998 American Hospital Association Guide.
[4] 1997 data from the State of New Hampshire Department of Health and Human Services.

Using 25% of cash, affiliate transactions reflect only pre-1997 events; after that the entities were consolidated. Though the hospital increased cash balances (8% of total cash uses), it also liquidated marketable securities, at a time when other hospitals in the state were building large discretionary cash balances.

This pattern of cash sources and uses presents a number of red flags related particularly to the financial drain of the affiliates and the hospital's newly-consolidated ventures.

Ratio Analysis 1993-98[5]

Profitability

The hospital's profitability is deteriorating and negatively affected by the large losses of SJHCS. These losses totaled $12M between 1993 and 1996. Prior to consolidation in 1997, the equity method was used to account for the investment in SJHCS' equity, so that its share in the losses were recognized as nonoperating losses on the income statement. Because these losses were so large, nonoperating activities represented an overall loss rather than gain to the hospital. This explains why the total margins were less than the operating margins prior to 1997.

After financial data was consolidated in 1997, we were unable to separately identify SJHCS' operating results. The consolidation of the nursing home facility operations may have also contributed to this decline in performance, though again, we were not able to determine the effect of individual subsidiaries (SJHCS, Surgi Center and Souhegan) on operating income in 1997 and 1998.

Despite the drop in operating income in 1997, the System was able to generate a positive total margin due to the contribution of nonoperating revenues, one-third of which were realized gains on the sale of investments. Income dependent on stock market performance is peripheral and may not be sustainable, especially given the System's net reduction in marketable securities. By 1998, nonoperating revenues were not sufficient to offset operating losses.

Liquidity

The hospital's liquidity deteriorated from 1993 to1996 as cash resources were transferred to affiliates and the hospital was unable to increase cash and marketable securities.

The current ratio declined after consolidation. Even with the inclusion of marketable securities, this measure is still weak relative to other hospitals in the state.

Despite the low current ratio and the large cash transfers to affiliates, the System has 49 days cash on hand with short-term sources and 106 days with the inclusion of marketable securities in the measure, as of 1998. Total cash and marketable securities, both board-designated and trustee-held, total $26M in 1998, only about $3M higher than the 1992 balance. Meanwhile, total debt is up by $11.5M.

Average pay period grew from 43 to 55 days, while days in accounts receivable have remained relatively stable, at roughly 55 days.

Capital Structure

The hospital is relatively leveraged compared to other hospitals in New Hampshire and nationally. As of 1998, the 37% equity financing ratio is low, as are debt coverage ratios.

[5] NH state medians from The 1998-99 Almanac of Hospital Financial & Operating Indicators.

Though no new debt was issued after 1994, solvency continued to decline through 1998. This unfavorable trend was a direct result of deteriorating equity, both as a result of equity transfers to affiliates and, more recently, deteriorating profitability. A 1998 debt service coverage ratio of .8 (operating income only) is a sign of serious financial strain.

As of 1998, the System can cover only a fraction (7%) of its total debt with cash flow from net income. With only cash flow from operations, this falls to 4%. Debt service coverage ratios reveal that cash flow from income is so low that the System can barely cover its debt principal and interest payments. When only cash flow from operating income is considered, the hospital cannot cover these payments. Erratic trends in these coverage ratios are a further red flag.

Charity Care and Community Benefits

Free care reported as charges forgone generally represented about 1-2% of gross patient service revenues. Free care at cost met the estimated value of the hospital's tax exemption with the exception of a few years (1993 and 1997). When 50% of the bad debt costs were added, free care met the estimate tax values in all years.

The hospital reported additional community benefits, such as educational programs, clinics, and transport services for which it receives no payment. The cumulative cost of these services was $1.2M. When these amounts were added to free care, free care amounts met the estimated tax value in all years except 1997.

In addition to charity care, the hospital offers HIV/AIDS services and a trauma center, which may be considered an additional charitable benefit to the community[1].

Source: Audited Financial Statements. Prepared by Nancy M. Kane, D.B.A. Harvard School of Public Health